Bloomsburg University of Pennsylvania

Accident/Incident/Injury Report

Date of Report: _________________

Please submit to the office of **Human Resources** by the end of the workday following the accident, incident, or injury. This form is to be completed by the person injured and/or involved in the accident/incident.

Is the person completing this form a: ☐ Student ☐ Employee ☐ Visitor ☐ Student Employee

Please Print or Type Responses

Date of Injury: ____________ Time of Injury: _____________

Date Reported to University Representative: _________________

Name: (Last) ______________________________ (First) ______________________________

Date of Birth: __________ ☐ Male ☐ Female Telephone Number: ____________

Street Address: ____

City: ___________________ County: ___________________ State:______ Zip: ________

Physician's Name: ______________________________ Telephone Number: _______________

Address: ____

Normal Starting Time: _________ Payroll Classification: __________ Date of Hire: _________

Did you complete a normal shift or teaching assignment on day of injury? ☐ Yes ☐ No

First day away from work due to injury (date): ________________

Date returned to work following injury: _____________________

Did you receive full pay for day of injury? ☐ Yes ☐ No Name of supervisor: ___________________

Where did the incident occur? (specific location): ____

____

____

Describe accident/incident (be specific and use additional paper if needed): _______________________________

____

____

____

What were you doing at the time of the accident/incident? ____

____

____

____

Identify any unsafe condition(s): ____

____

Identify all equipment, materials, or chemicals employee was using when accident or illness exposure occurred:

____

____

How would you prevent this accident/incident from recurring? _______________________________________

____

Did anyone witness the accident/ incident? ☐ Yes ☐ No

If yes, give names: ____

Did you sustain an injury? ☐ Yes ☐ No

If yes, what body part was affected? ____

____

☐ Left Side ☐ Right Side ☐ N/A

Please describe the injury:

____

____

____

Initial treatment:

☐ No Medical Treatment ☐ Minor Treatment by Employee ☐ Clinic/Hospital
☐ Panel Physician ☐ Employee Physician ☐ Emergency Care ☐ Hospitalization for More Than 24 Hours

Did you sustain damage to personal property? ☐ Yes ☐ No
If yes, describe:____

Employee Signature: _________________________________ **Date:**________________________